Solicitation Information
July 22, 2016

RFP# 7550811

TITLE: ADMISSION SCREENING AND UTILIZATION REVIEW MANAGEMENT

Submission Deadline: August 18, 2016 at 10:00 AM (Eastern Time)

PRE-BID/ PROPOSAL CONFERENCE: No

Questions concerning this solicitation must be received by the Division of Purchases at david.francis@purchasing.ri.gov no later than **August 2, 2016 at 10:00 AM (ET).** Questions should be submitted in a *Microsoft Word attachment.* Please reference the RFP# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

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Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri .gov .

Note to Applicants:

Offers received without the entire completed three-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

TABLE OF CONTENTS

Section 1 –Introduction……..……..…….…..3

Section 2- Background ……... 5

Section 3- Scope of Work……... 8
General Scope of Work……..... 8
Specific Activities / Tasks…… 10
.
Section 4 -Technical Proposal…….…… 25

Section 5 -Cost Proposal…….….. 26

Section 6- Evaluation and Selection……. 27

Section 7 -Proposal Submission……28

Appendix A- Glossary of Terms ……... 30

Appendix B- Reporting Requirements ……33

Appendix C- Cost Proposal Forms …….. 39

SECTION 1: INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Executive Office of Health and Human Service is soliciting proposals from qualified firms to provide Admission Screening and Utilization Review Program services for Medicaid recipients in the Medicaid fee-for-service system, in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at www.purchasing.ri.gov .

The initial contract period will begin approximately January 1, 2017 for three years. Contracts may be renewed for up to two additional 12-month periods based on vendor performance and the availability of funds.

This is a Request for Proposals, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.

2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP will be rejected as being non-responsive.

3. All costs associated with developing or submitting a proposal in response to this RFP, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for these costs.

4. Proposals are considered to be irrevocable for a period of not less than 60 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.

5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.

6. Proposals misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.

7. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all aspects of the work. Joint venture

and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

8. All proposals should include the vendor's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's website at www.purchasing.ri.gov.

9. The purchase of services under an award made pursuant to this RFP will be contingent on the availability of funds.

10. Vendors are advised that all materials submitted to the State for consideration in response to this RFP will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.

11. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.

12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation.

13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).

14. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information visit the website www.mbe.ri.gov

15. Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement

16. In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI) , the vendor hereby certifies that it is an "eligible entity," as defined

by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an "eligible entity," as defined by 45 C.F.R. § 155.110.

SECTION 2: BACKGROUND

The Rhode Island Department of Administration - Division of Purchases, on behalf of the Executive Office of Health and Human Services (hereinafter called EOHHS) is soliciting proposals from qualified organizations to establish and operate an Admission Screening and Utilization Review Program to determine the medical necessity, quality of care, and appropriateness of services rendered to Medicaid recipients (hereinafter called recipients) and to monitor and control the utilization of acute inpatient hospital services and prevention of unnecessary readmissions. The services provided through this contract will be for recipients in the Medicaid fee-for-service system. Medicaid beneficiaries enrolled in managed care plans are not covered by this procurement, except for the evaluation functions within the preadmission screening and resident review (PASRR) evaluation process.

This chapter provides an overview about the State's Medicaid program, the Rhode Island Comprehensive section 1115(a) Medicaid demonstration, and conditions that influence the conduct of admission screening and utilization activities in the Medicaid program.

Overview of the Rhode Island Medicaid Program

The Medicaid Program is a health care entitlement program for the State's low-income population that is jointly funded by the Federal Government and Rhode Island. Medicaid was established in 1965 as Title XIX of the U.S. Social Security Act. EOHHS is the federally required Single State Agency (SSA) responsible for the administration of Medicaid.

Medicaid is an integral part of the State's health care delivery system because it touches the lives of so many individuals. Today over 280,000 individuals are enrolled in the Rhode Island Medicaid Program, at a cost of almost $2.3 billion dollars.

When Medicaid began in the mid-1960s, the program was modeled as a traditional indemnity health insurance program. Medicaid was a payer of health care services based on a fee-for-service (FFS) payment system. Medicaid has now evolved from this somewhat passive role of a payer of claims into a value-purchaser of health care services**.**

The State's managed care program RIte Care, began in 1994, with the Aid to Families with Dependent Children (AFDC), now the Temporary Assistance to Needy Families (TANF) program, and has expanded over the years to cover other special related populations including pregnant women and other special children. Today, all children and families without other third party coverage are required to enroll in a managed care health plan. Throughout the years Rhode Island's adult aged, blind and disabled (ABD) populations were provided services through the Medicaid FFS system. Today, all adults without third-party coverage in the ABD program are required to enroll in a Health Plan.

Rhode Island implemented the RIte Share program in January 2001 to provide assistance in paying for health care premiums for commercial insurance to cover eligible children and eligible adults as well as some limited medically necessary wrap-around services (the wrap-around services are provided through the Medicaid FFS system).

In 2013 Rhode Island joined in the expansion of Medicaid provided for under the Affordable Care Act (ACA). This expansion called for Medicaid coverage for all legally-present residents in the US with household incomes up to 133 percent of poverty level, as well as coverage for other smaller groups.

Rhode Island Comprehensive Section 1115(a) Medicaid Demonstration

The Rhode Island Medicaid Reform Act of 2008 (R.I.G.L §42-12.4) directed the state to apply for a global demonstration project under the authority of section 1115(a) of Title XI of the Social Security Act (the Act) to restructure the state's Medicaid program to establish a "sustainable cost-effective, person-centered and opportunity driven program utilizing competitive and value-based purchasing to maximize available service options" and "a results-oriented system of coordinated care."

Toward this end, Rhode Island's Comprehensive demonstration establishes a new State-Federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines. Rhode Island will use the additional flexibility afforded by the waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure that beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

Under this demonstration, Rhode Island operates its entire Medicaid program subject to the financial limitations of this section 1115 demonstration project, with the exception of: 1) disproportionate share hospital (DSH) payments; 2) administrative expenses; 3) phased-Part D contributions; and 4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third party payer.

With those four exceptions, all Medicaid funded services on the continuum of care – from preventive care in the home and community to care in high-intensity hospital settings to long-term and end-of life-care whether furnished under the approved state plan, or in accordance with waivers or expenditure authorities granted under this demonstration or otherwise, are subject to the requirements of the demonstration. Rhode Island's previous section 1115 demonstration programs, RIte Care and RIte Share, were subsumed under this demonstration, in addition to the state's previous section 1915(b) Dental Waiver and the state's previous section 1915(c) home and community-based services (HCBS) waivers.

The Rhode Island Comprehensive demonstration includes the following distinct components:

a. The Managed Care component provides Medicaid state plan benefits as well as supplemental benefits as identified in Attachment A to most recipients eligible under the Medicaid state plan, including the new adult group effective January 1, 2014.

b. The Extended Family Planning component provides access to family planning and referrals to primary care services for women whose family income is at or below 200 percent of the federal poverty level (FPL), and who lose Medicaid eligibility under Rite Care at the conclusion of their 60-day postpartum period. Effective January 1, 2014, eligibility will be raised to 250 percent of the FPL.

c. The RIte Share premium assistance component enrolls individuals who are eligible for Medicaid/CHIP, and who are employees or dependents of an employee of an employer that offers a "qualified" plan into the ESI coverage.

d. Effective through December 31, 2013, the Rhody Health Partners component provides Medicaid state plan and demonstration benefits through a managed care delivery system to aged, blind, and disabled beneficiaries who have no other health insurance.

e. The Connect Care Choice component provides Medicaid state plan benefits to aged, blind, and disabled beneficiaries who have no other health insurance, through a primary care case management system. *

f. The Home and Community-Based Service component provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need home and community based services either as an alternative to institutionalization or otherwise based on medical need.

g. The RIte Smiles Program is a managed dental benefit program for Medicaid eligible children born after May 1, 2000.

h. Rhody Health Options is a managed care delivery system for Medicaid only and Medicare Medicaid eligibles that integrates acute and primary care and long term care services and supports.

In 2013, CMS renewed the Comprehensive demonstration through December 31, 2018. This renewal includes changes to support the state's implementation of the Affordable Care Act (including coverage of the new adult group for adults with incomes at or below 133 percent of the FPL), the expansion of the state's home and community based services (HCBS), and the conversion from an aggregate cap to a per member per month budget neutrality model.

Conditions that Influence the Conduct of Screening and Utilization Review Activities.

There are several factors that impact on the conduct of screening and utilization review activities and the number of beneficiaries that are covered by this procurement including:

- All children and families are required to enroll in a Health Plan under the RIte Care Program thus reducing the number of beneficiaries in the Medicaid fee-for-service-system.

- The State is committed to restructuring how it pays providers for services and has implemented a Diagnostically Related Groups (DRGs) to reimburse hospital for in-patient care thus reducing the number of continued stay reviews required to be conducted.

- EOHHS is committed to implement program improvement strategies that improve the quality

* The Connect Care Choice Primary Care Case Management program has been re-designed under the Reinventing Medicaid initiative. The re-designed Primary Care Case Management program is Community Health Team-RI (CHT-RI). The CHT-RI program is for eligible Medicaid adult members who do not receive care management, are not enrolled in a health plan, and who will now have access to care management services.

and value of Medicaid services.

Of the approximately, 280,000 Medicaid recipients, 263,000 are enrolled in a Managed Care Plan and the remaining 17,000 are in the fee-for-service system.

It is estimated that 17,000 Medicaid recipients will be covered by this procurement, where Medicaid is primary or the recipient's benefits have been depleted by other third party coverage. This estimate is subject to fluctuation during the proposed contract period.

SECTION 3: SCOPE OF WORK

General Scope of Work

The objective of this Request for Proposal (RFP) is to competitively procure the services of a qualified organization to perform three essential functions that comprise the scope of work for this procurement.

- **Admission Screening Program:** The successful Contractor shall establish and operate an Admission Screening Program to determine the medical necessity, and appropriateness of services for specified Medicaid recipient groups for admission to acute in-patient facilities and to two selected psychiatric hospitals for specified populations. Under the Admission Screening Program, the Contractor shall employ nationally recognized review criteria to ensure that medical, surgical and psychiatric services are provided in the most appropriate and cost-effective setting.

- **Utilization Review and Management:** For DRG outlier cases, hospital stays shall be further monitored concurrently with the recipient's hospital stay to identify when a continued stay is no longer medically necessary, and retrospectively to identify any days of a Medicaid recipient's hospital stay that were not medically or administratively necessary and any ancillary services delivered which were not medically necessary or which were inappropriately billed.

  Retrospective reviews shall be conducted for patients becoming Medicaid eligible after admissions.

  Quality of Care reviews shall be conducted for hospitals selected by EOHHS.

- **PASRR Evaluations:** The Contractor shall conduct Level II evaluations and continued stay (resident) reviews of mentally ill persons in nursing facilities. The evaluations shall be conducted in the nursing facilities.

  Appendix A is a glossary of terms related to this procurement.

The Table below indicates the estimated magnitude of the scope of work performed in State Fiscal Year 2015 related to this procurement.

ACTIVITIES	NUMBER CONDUCTED SFY 2015
Admission Screening	
Inpatient screens	2,727
Outpatient screens	18
Psychiatric inpatient admission screens	233
NICU screens	540
Subtotal	3,518
Utilization Reviews	
Concurrent reviews	106
Psychiatric facility concurrent/LOS reviews	147
NICU concurrent/LOS reviews	0
Retrospective reviews	1,927
Retrospective readmissions	0
Psychiatric facility retrospective reviews	110
Subtotal	2,290
PASRR	
Evaluations	116
TOTAL REVIEWS	5,924

Specific Activities / Tasks

GENERAL

Compliance with Federal and State Requirements

The Contractor shall comply with all Federal and State existing and future general and Medicaid specific requirements that govern the conduct of the proposed as scope of work, including requirements related to utilization review activities (e.g. RIGL 92-398, Chapter 17.12 an Act to assure Fair and Effective Utilization Review of Health Care Services and the Rules and Regulations for the Utilization Review of Health Care Services (R23-17.12-1-UR). The Contractor shall comply with CFR 42.483, C, in administering the PASRR functions under this RFP.

The successful contractor also shall comply with the EOHHS Code of Administrative Rules and Regulations (The official code is only accessible, in paper format, on-site at the Office of Secretary of State).

Scope of Work

The Contractor shall be able to conduct the admission screening, utilization reviews and management, and PASRR evaluations as described in this RFP and the executed contract between the successful bidder and the State.

The Contractor shall also comply with any mutually agreed upon amendments to the scope of work.

Organizational Requirements

Interested parties shall be registered with the Department of Administration. Foreign companies shall have a Certificate of Authority from the Secretary of State to transact business in this state and to provide services under this contract

Bidders must be licensed by the Rhode Island Department of Health to serve as a Utilization Review company under this procurement and accredited by a nationally recognized body.

The bidder shall be a Quality Improvement Organization (QIO) or one of other types of entities recognized and approved by the Secretary of the Federal Department of Health and Human Services, such as an External Quality Review Organization (EQRO), or a utilization and quality control peer review organization.

Termination

The State reserves the right to terminate this contract for good cause with 60 days notification to the Contractor.

OPERATIONAL/ ADMINISTRATIVE

Qualifications/Experience

The successful bidder shall have, at minimum, three years of experience serving in an admission screening and utilization capacity and two years' experience with a Medicaid population and must provide relevant information about similar or related contracts including a description of the work performed.

The bidder must guarantee the ability to commence providing services upon signing a contract and the ability to carry out the full volume of services specified in this RFP.

The bidder must demonstrate knowledge about the Rhode Island environment.

Bidders who do not meet minimum qualifications will not be reviewed.

Referral Center

The Contractor shall establish and maintain at least one referral center in Rhode Island or in a contiguous state. The referral center(s) shall be open during business hours Monday through Friday (8:00 AM - 5:00 PM Eastern Time) and be adequately staffed to receive incoming calls in a timely manner. A toll-free number must be available for areas outside of the direct-dialing area.

Overall Staffing:

The Contractor shall recruit, select, train and manage appropriate and qualified personnel to meet the Scope of Work of the Base and Special Engagements. The staff shall include, but not be limited to, the following:

- A Project Manager who shall be responsible for overseeing all activities described in the Scope of Work
- Utilization Review Registered Nurses with clinical experience of not less than five years and other clinical experience relative to areas of utilization review
- Physicians with board certification in various areas of specialty and experience in settings similar to physicians in Rhode Island and also experienced in Peer Review, including a board certified neonatologist and psychiatrist
- Data Management Personnel
- Clerical and Support Staff
- Licensed clinical social workers or other qualified staff to perform Level II PASRR evaluations**,** registered nurses with experience serving disabled adults or the elder population with complex medical conditions, and registered nurses with recent experience in neo-natal care, and
- Other staff the Contractor believes is necessary to complete the scope of work described in this RFP.

Coordination

The Contractor shall:

- Review CMS and Rhode Island regulations, policies, and procedures to determine the need for regulatory, policy, or procedure changes that may be required to support the scope-of-work
- Develop and draft for EOHHS recommendations regarding policies and procedures.
- Develop all forms and reporting formats and procedures required for the scope-of-work contained in this RFP.
- Develop and implement a plan in conjunction with EOHHS in order to transfer the admission screening and concurrent review information to the EOHHS at a minimum of twice weekly. This plan will also include an established procedure for updating information, including but not limited to dates of admission and discharge, and will include a process to verify that calls are not a duplication of previous calls for the same dates of service, procedures, or diagnosis. Relevant information on cases in the concurrent review process shall be included in this plan.
- Integrate and communicate with State's MMIS claims and management system.
- Notify the admitting provider and hospital, in writing, of any incorrect information that preclude data being accepted by EOHHS.
- Coordinate and cooperate with other agencies, Contractors or entities.
- Comply with statutory, regulatory, confidentiality and program standards.
- Attend meetings or seminars as requested by EOHHS.

Provider Relations

The Contractor shall maintain a professional working relationship with providers requesting service.

The Contractor shall respond to provider and recipient inquiries regarding admission screening and utilization review programs.

The Contractor shall maintain sufficient telephone capacity to handle these inquiries on a toll-free number.

The Contractor shall develop and implement a procedure for the investigation and resolution of provider and recipient complaints regarding the Contractor's performance and inform EOHHS on a monthly basis of the number and types of complaints filed and of the results of any investigation.

Subcontracting

The Contractor, with State approval, may employ subcontractors. The State encourages the subcontracting with small businesses, minority business or provider networks.

Specific responsibilities and tasks that the sub-contractor shall perform shall be delineated. The prime Contractor shall be held accountable and is responsible for all sub-contractor work.

All requirements contained in this RFP and terms and conditions of the contract, also apply to sub-contractors. The contractor shall provide copies of all sub-contracting agreements upon request.

ADMISSION SCREENING PROGRAM

Scope and Affected Cases

The Admission Screening Program covers all inpatient acute hospital services to be provided to all categories of Medicaid recipients in Rhode Island and border acute care hospitals, unless specifically exempted by regulation. The admission-screening program does not waive, replace or have precedence over any other EOHHS requirements such as prior authorization, utilization review, or consent form requirements.

Admission Screening is required for the following:

- All medical, surgical, rehab and psychiatric unit admissions for un-exempted recipients.
- Postponed admissions for un-exempted recipients.
- Admissions to ER/observation status.
- Admission that convert to Medicaid as a primary payer.

Client Populations

Admission screening shall be conducted for:

- All Medicaid recipients 21 years and older in the fee-for-service system.
- Dual Eligible beneficiaries who have exhausted their Medicare benefits.
- Beneficiaries under 21 who are the responsibility of the Rhode Island Department of Children, Youth and Families (DCYF) for admission to Butler and Bradley Hospitals for in-patient psychiatric care.
- Newborns in NICU.

Admission screening shall not be required for the following Medicaid recipients:

- Enrolled in a Medicaid Managed Care Plan including any of the Rhody Health Plan members
- Enrolled in a Coordinated Health Plan with TPL that includes hospitalization
- For normal labor and delivery for those enrolled in Medicaid fee-for-service (FFS)
- Whose hospitalization is court-ordered

- For those enrolled in Medicare Part A unless benefits have been exhausted. (Recipients with Medicare Part B coverage only are not exempt)

Clinical Protocol

The nurse reviewer and consulting physician shall use the Interqual Criteria Set to assess the severity of illness, intensity of care required to determine the appropriateness of admissions and level of care and required for admission.

Staffing

The admission screening assessment shall be conducted by a registered nurse, with preferably at least five years' experience serving the disabled adult or elders with complex medical conditions.

The Contactor shall also provide a full time nurse, with at least three years' experience, to conduct admission, concurrent review and discharge planning activities at the NICU in Women and Infants Hospital.

Intake

The Contractor's review process shall be triggered by a telephone call from the admitting provider within the specified time lines enumerated in the Provider's Responsibilities section, below. Initial reviews shall consist of a telephone discussion between the admitting provider or an individual designated by the provider and a qualified, trained registered nurse reviewer employed by the Contractor. The Contractor shall process each screening case as follows:

- The Contractor's nurse reviewer upon initiating a case with an admitting provider shall assign a unique screening reference number for the case and inform the admitting provider of that number.

- The nurse reviewer shall request the following information from the admitting provider and record such information in the Contractor's data system:

  -the recipient's name and address,
  -the recipient's sex,
  -the recipient's date of birth
  -the recipient's social security number,
  -the recipient's identification number,
  -the recipient's category of assistance,
  -the mother's name, DOB, SSN for NICU patients,
  -the name of the mother's RIte Care Plan for NICU patients,
  -the primary and secondary diagnosis and co-morbidities,
  -the primary and secondary procedures, if applicable,
  -the expected or actual date of admission and the expected date of discharge,
  -the preliminary discharge plan,
  -the admitting provider's Medical Assistance provider number,
  -the admitting provider's type (i.e., specialty),
  -the hospital's name,

-other information that the physician has taken into consideration in deciding to admit or perform a procedure on an inpatient basis (for example-available support services and restrictive home environment), and
-source of payment (i.e., other insurance resource and information related to whether the admission resulted from an accident, including date and type of accident, if available).

The Contractor's reviewer shall review the recipient's identification number against the eligibility information provided by EOHHS. If the recipient's identification number cannot be validated against EOHHS's information, utilizing both the Web based access or the REV's line, the Contractor shall refer the recipient case back to the hospital for verification of recipient's Medicaid fee-for-service eligibility prior to performing any review. The Contractor shall not attempt to determine the recipient's eligibility for Medical Assistance.

The nurse reviewer shall consider home environmental restrictions and availability of supportive resources. If the nurse reviewer determines that home support is necessary, but inadequate, an admission shall be approved and/or lengths of stay extended.

When assessing the appropriateness of an admission, the Contractor's reviewer shall include and evaluate summary data.

Inpatient Admissions (medical, surgical, rehab and psychiatric units)

The nurse reviewer shall review the admitting provider's proposed admission, which shall include the treatment site, length of stay, discharge plan, and any preoperative days against clinical protocols. The review shall result in one of the following:

- An agreement between the Contractor's reviewer and the provider or the provider's designee that an acute hospital admission and the assigned length of stay.

- An agreement between the Contractor's nurse reviewer and the provider or provider's designee that the procedures may be performed safely in another setting.

- A disagreement between the Contractor's nurse reviewer and the provider or the provider's designee with the proposed admission and length of stay.

- The nurse reviewer shall deny the admission, recommend an alternative treatment site, or recommend a different length of stay.

- If the admitting provider disagrees with the nurse reviewer's decision, the nurse reviewer shall refer the case to a physician advisor.

- The physician advisor shall contact the admitting provider (not the provider's designee) no later than the same time on the following business day.

- The physician advisor shall discuss the case with the admitting provider and review any relevant information submitted by the admitting provider to justify the medical necessity of an acute inpatient admission and proposed length of stay.

- The Contractor's physician advisor shall make a determination regarding the appropriateness of the admission, any preoperative days, and/or length of stay.

- If the physician advisor agrees, the Contractor shall notify EOHHS that admission screening requirements are met.

- If the physician advisor and the admitting provider are unable to agree on the admission and/or preoperative days, the Contractor shall notify the recipient, the hospital, and the admitting provider that the claim for payment has been denied and identify the process for an expedited hearing.

- If the physician advisor and the admitting provider agree on the admission and any preoperative days but disagree on the length of stay and the length of stay will exceed the stay assigned by the physician advisor, the Contractor shall notify the EOHHS or its designee that admission- screening requirements are met and identify claims from the admitting provider and the hospital for utilization review.

Admission to ER/Observation Review

The nurse reviewer shall review all ER admissions that result in admission to observation status for 24 to 48 hours.

The nurse reviewer shall identify all cases that are likely to be converted to Medicaid and those cases that are likely to exceed beyond the DRG lengths of stay (LOS). These cases shall be subject to concurrent review.

The Contractor's nurse reviewers shall track those cases and review them prior to converting to Medicaid. The nurse shall initiate contact with the admitting physician and notify the State's MMIS Claims and Management System.

Identify Accident Cases

The Contractor shall identify all admissions resulting from an accident, (such as, but not limited to automobile, household, other travel, workplace, commercial properties, crime, etc), as part of the admission screening process. The referrals shall be reported weekly and sent to EOHHS's Third Party Liability (TPL) Unit.

Identify Cases in Disease Management Programs

The Contractor shall flag their system to identify all admissions that are currently in a Disease Management / Chronic Care Management Program through EOHHS and any collaborating partners. These identified admissions will be reported to the appropriate contact person as identified by EOHHS as they occur.

Notify Parties of Decision

In writing, the Contractor shall notify the physician, the patient, and the hospital of its decision within twenty-four (24) hours of the first working day of the admission screening call. The notification shall include:

- the recipient's social security number
- the recipient's identification number
- the recipient's gender
- the recipient's date of birth
- the primary and secondary diagnoses
- the primary and secondary procedures
- the preliminary discharge plan
- the source of payment
- the admitting provider's Medical Assistance provider number
- the admitting provider's type
- the hospital's name
- the recipient's category of service
- the date of admission and discharge (assigned length of stay)
- the screening reference number

If an admission has been denied, the Contractor shall provide the hospitals and recipients with an expedited hearing form.

Appeals Process

If the Contractor's physician advisor determines that a hospital admission or hospital stay is not medically necessary or that the services may be safely provided in another setting, the admitting provider may submit a written request within seven (7) days after the initial determination for review by the Contractor. The Contractor shall review all documentation submitted by the admitting provider pertinent to a second review and shall make a final determination.

The Contractor shall provide as necessary, in-person representation to explain or justify any final determination made by the Contractor and assist EOHHS in any fair hearing or adjudicator proceeding resulting from any actions taken or decisions made under this Admission Screening Program.

Provider Responsibilities

Provider's responsibilities are noted below:

Elective Admissions: The admitting physician or physician designated shall telephone the Contractor at least seven (7) calendar days prior to the proposed admission and provide the information requested by the Contractor.

When it is not possible for the admitting physician to comply with the seven-day prior notice requirement, the admitting provider shall telephone the Contractor by 5:00 PM on the first business day after the decision to admit and, in any event, prior to the admission.

Emergency and Psychiatric-Unit Admissions Subject to Admission Screening: The admitting physician or physician designee shall telephone the Contractor no later than 5:00 PM on the second business day following the admission and provide the information requested by the Contractor. The provider shall telephone the Contractor when the diagnosis of an admission changes in the course of the hospitalization from one where admission screening was not required to one where a provider must call for admission screening.

Requests for Extensions: The admitting physician or physician designee shall telephone the Contractor no less than 48 hours prior to the expiration of the assigned length of stay and indicate the medical necessity for an extension, unless the admitting physician has been contacted by the Contractor for concurrent review prior to the expiration of the assigned length of stay.

UTILIZATION REVIEW AND MANAGEMENT PROGRAM REQUIREMENTS

Three types of reviews shall be conducted under the Utilization Review and Management Program, as discussed below.

Concurrent Review

Concurrent reviews shall be conducted on hospitals not covered by the DRG system (e.g. .Butler and Bradley), and for those outlier cases exceeding DRG guidelines. The purpose of these reviews is to assure the medical necessity and appropriateness of care. The reviews shall identify when a continued stay is no longer necessary, and any days of a Medicaid recipient's hospital stay which were not medically necessary.

The Contractor shall conduct concurrent reviews by telephone for those admissions with psychiatric and substance abuse diagnoses admitted to a psychiatric unit in an acute medical/surgical inpatient hospital and all emergency admissions. The Contractor shall conduct concurrent reviews on-site for NICU admissions.

Concurrent review shall be performed for all such admissions within 24 hours of the next business day and shall include a rigorous continued stay review of an admission with frequent contact between the Contractor and the hospital to limit, where appropriate, the length of stay only to those days that are medically necessary. For those cases designated for concurrent review, the Contractor shall telephone the provider at appropriate intervals but not less than 48 hours prior to the expiration of the assigned length of stay.

The Contractor shall review the proposed treatment plan for continued stay against clinical protocols for length of stay certification. The Contractor shall modify the type of cases targeted for concurrent review as requested by EOHHS and revise applicable criteria accordingly.

The Contractor shall profile types of admissions and recommend modification in concurrent reviews.

Upon receiving cases flagged during the admission screening process, the concurrent nurse reviewer shall contact the hospital's Utilization Review Department or appropriate personnel by telephone within two (2) business days of notification.

The Contractor shall rigorously review the appropriateness of continuing hospitalization based on established and current medical care criteria and standards specifically designed for the targeted admissions.

The Contractor shall review the admitting diagnosis or condition with the admitting provider based on the applicable criteria such as treatment and discharge planning.

The review shall result in the same possible outcomes for extensions of assigned lengths of stay.

The Contractor shall report to EOHHS on cases where concurrent review resulted in reducing the number of days of the hospitalization.

Retrospective Reviews

The Contractor shall conduct retrospective reviews at the facility of Medical Assistance to detect recipients who become eligible after admission and/or discharge from a facility, and selected out-of-state inpatient admissions.

The Contractor shall:

- Submit to EOHHS on a Monthly basis a list of hospitals for which the Contractor shall conduct quarterly retrospective reviews including the tentative dates for each review and the review period.

- Notify the hospital administrator, the hospital Utilization Review Department, and the hospital Medical Records Department in writing of the scheduled on-site visit at least two weeks in advance and include in the notification, a list of records to be reviewed.

- Perform the on-site retrospective review through a team of nurses with a physician consultant available during the review.

- Conduct reviews on all cases based on established clinical protocols. Any cases not meeting the criteria shall be referred for a peer review prior to a determination that a service was not medically necessary or that care was not provided in an efficient manner that resulted in an extended length of stay.

- Photocopy all records necessary to support discrepancy areas.

- Prepare a report of its findings for each review.

- Perform an exit briefing with the provider on the last day of the on-site review to explain preliminary findings and to furnish the provider with a list of missing information and inform the provider that the provider has ten (10) days in which to respond.

- Review additional materials submitted by the provider within ten (10) days of the exit briefing and, if appropriate, revise the audit report.

- Provide EOHHS and the provider with the results of the final review within fifteen (15) working days of the completed on-site review.

- Present and clarify its findings at OHHS conferences or adjudicator hearings as requested by EOHHS.

Quality of Care Assurance

The Contractor shall conduct Quality of Care Studies to assess hospital compliance with EOHHS requirements as well as nationally accepted standards of care. The studies shall address assess the quality and effectiveness of care and suggest specific improvement strategies for the hospital and EOHHS that improves the efficiency and effectiveness of care.

The Contractor shall identify for EOHHS potential studies for conduct and prepare a study design for EOHHS for the selected study. The Contractor will conduct at least one Quality of Care study, annually.

The Contractor shall also identify and review all cases that meet the Medicare definition of "Premature Discharge", according to the Medicare Policy for denial of readmissions meeting the "Medicare Premature Discharge Criteria."

The Contractor shall report monthly on problems that present an opportunity to resolve through changes in State or hospital policy and procedures.

Staffing

The utilization review and management program shall be conducted by registered nurses, with preferably, at least five years' experience serving the disabled adult or elders with complex medical conditions.

PASRR EVALUATION REQUIREMENTS

The Pre-Admission Screen and Resident Review (PASRR) process is mandated by the federal Center for Medicare and Medicaid Services (CMS). The purpose of PASRR is three fold:

- To assure that all candidates for admission to Medicaid certified nursing facilities are properly screened for the existence of serious mental illness (MI), intellectual disability / intellectual development disability (ID/DD), or related condition (RC/DD).

- To prevent the inappropriate admission to nursing facilities of individuals with MI, ID/DD, or RC/DD, as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA).

- To assure that proper treatment plans are formulated for residents in nursing facilities who have MI, ID/DD, or RC/DD, in order for them to receive specialized services or specialized rehabilitative services.

Screening Process

The PASRR program requires that 1) all individuals, regardless of payer source, receive a Level I preadmission screen prior to admission, 2) individuals who test positive for possibly having a MI, ID/DD, or RC through the Level I screen be referred to the appropriate PASRR authority for a comprehensive Level II evaluation resulting in two determinations; whether NH admission is appropriate and whether the person needs specialized services and/or specialized rehabilitative services.

The Level I Preadmission screen for hospitalized individuals is usually completed by hospital staff and by a community provider for those being admitted from the community. If the Level I preadmission screen does not trigger need for a Level II evaluation, or the Level I screen triggers for a level II evaluation but the individual has met the hospital discharge exemption criteria, the individual may be admitted to the Nursing facility.

If the Level I screen does identify or suspect MI, ID/IDD, or RC/DD the process must continue to the Level II evaluation. The hospital staff or community provider, as applicable, will often complete the Level II evaluation. Individuals may be admitted to nursing facilities prior to the completion of the entire process under specific exemption conditions. These may include a 30-day ID Screen exemption, a PASRR Level II exemption for delirium or respite care, or an emergency nursing facility placement. A complete Level II evaluation may later be required for these residents.

In addition to individuals admitted under these exemption conditions, other current nursing facility residents may require resident reviews or Level II assessments for a variety of reasons. A current resident may have a significant change in mental status, a change in condition, a newly identified or suspected serious mental illness, or may not be responding to the current treatment plan. Periodic resident reviews are also required for residents under certain conditions. The potential contractor under this procurement shall conduct the Level II evaluations for all patients under these circumstances, who have been identified or suspected of MI.

Shared Responsibilities

The PASRR process and oversight is shared among EOHHS; The Department of Behavioral healthcare, Developmental Disabilities and Hospitals (BHDDH) -the state's mental health authority (SMHA), and The Department of Health (DOH), in their role as the state survey agency.

EOHHS, the single state agency for Medicaid, has the overall responsibility for the PASRR program. As the PASRR process is mandated by CMS, the Medicaid agency's role is to ensure that the process is followed as mandated.

BHDDH is responsible for all Level II PASRR evaluations and determinations resulting in identified or suspected ID/DD, or RC/DD and will make the final determination to either make or verify a diagnosis of these conditions. BHDDH will then make two determinations, a) Appropriateness of NH services and, b) the need for specialized services. BHDDH bears the same responsibilities for determinations resulting in

identified or suspected MI, but is precluded by federal law from conducting the evaluations. The potential contractor under this procurement shall conduct the Level II evaluations for all patients residing in nursing facilities who have been identified or suspected of MI. See PASSR evaluator functions.

DOH will continue their role as the state survey agency by sampling residents with serious mental illness and ID/IDD. The survey agency will also review all PASRR documentation for timely completion, and nursing facility care plan requirements within the survey sample.

Staffing

The Contractor shall provide staff to fill three positions:

- A Project Manager to oversee the PASRR program and to conduct the necessary inter-agency functions required to assure successful and timely completion of project activities.

- A PASRR Evaluator(s) to conduct the Level II evaluations.

- A Psychiatrist to provide medical oversight and consultation about specific cases.

The PASRR Evaluator shall be: (1) a licensed clinical social worker (LCSW) with a behavioral health focus, (2) a certified clinical nurse specialist in behavioral health, or (3) a licensed advance practice psychiatric nurse with, preferably, at least five years' experience in behavioral health. The evaluator shall have experience in validating MI diagnosis and a solid understanding in the provision of specialized services in Rhode Island through the PASRR program. Experience in long term care and conducting evaluations are a plus. The Evaluator shall be able to work independently with minimal supervision and possess strong communication and computer skills.

The staffing of the PASRR Evaluator may be sub-contracted to an entity that has the staffing and clinical expertise to meet the requirements listed herein such as a Community Mental Health Center in collaboration with the BHDDH.

Evaluator Functions

The following describes the basic functions that shall be performed by the Contractor:

- Receive requests or cancellations for Level II evaluations from the nursing facilities and the SMHA. Prioritize requests for the resident reviews in collaboration with the SMHA. The SMHA maintains overall authority for determination of need for repeat resident reviews, additional evaluations, and informational updates.

- Contact nursing facilities to make appointments for the Level II evaluations.

- Conduct on-site assessments of new nursing facility admissions as well as re-evaluations for continued stay reviews within prescribed time frames and complete all paper work while maintaining flexible hours.

- Maintain data on a spread sheet (EXCEL) regarding name, DOB, and social security number of all resident's referred, the nursing facility, the date of the completed notification, the date the request

was received, the reason for the evaluation, the date(s) of the scheduled, actual, and canceled resident review, evaluation location, and the outcome of the review.

- Each PASRR evaluation shall include verbal communication with the Nursing Facility staff, an interview with the resident, and family member if applicable, record review, and a written report which includes recommendations for care planning.

- Generate reports for EOHHS and the SMHA. As reviews are completed, the PASRR evaluator shall forward the completed Nursing Facility resident review log with all of the required evaluation materials to the SMHA for review and determination.
- Resident reviews suggesting further evaluation for specialized services require immediate consultation with the SMHA and the Nursing Facility supervisory personnel followed by an immediate written report given to the Nursing Facility and faxed to the SMHA for determination of need for Community Mental Health Center Extended Level II evaluation.
- The PASRR evaluator shall provide education and clinical consultation to EOHHS, the state Medicaid Agency, BHDDH and DOH in their roles as the responsible state agencies for the PASRR Program, when needed.

The project manager and the PASRR evaluator will be available to attend at least quarterly interdepartmental meetings with the SMHA (State Mental Health Authority), the SMA (State Medicaid Agency) and DOH (State Survey Agency) as necessary.

Liability

The Contractor shall not be held liable for any direct, indirect, special, consequential, or incidental damages to State of Rhode Island or any other person or entity related to PASRR.

REPORTING REQUIREMENTS

Three types of reports shall be required of the Contractor: (1) a monthly report, (2) specific reports related to the scope of work areas, and (3) an annual report. These reports are described below.

Monthly Report

The Contractor's Project Manager shall submit a monthly report and conduct a briefing to inform EOHHS staff about: (1) planned versus actual project activities, including the number of admission screenings, utilization reviews, PASRR evaluations conducted (2) activities planned for the subsequent month, (3) problems encountered or emerging issues and potential solutions, (4) suggestions to improve the effectiveness and efficiency of care or the Medicaid program, (5) highlights of meetings or work sessions attended on behalf of EOHHS, and (6) proposed changes in project work plan or budget, if any.

One hard copy and an electronic version of the Monthly Report shall be submitted to the EOHHS Project Director no later than five business days after the month covered by the Monthly Report. The Contractor shall conduct the monthly briefing shortly thereafter based on EOHHS Contract Manager's schedule.

Scope of Work Specific Reports

The Contractor shall be required to submit to EOHHS specific reports for scope of work area covered by this procurement. The specific reports are contained in Appendix B. The Contractor shall only make changes in these reports with the approval of the EOHHS Contract Manager.

Annual Report

The Contractor shall submit an Annual Performance Measure Report to the EOHHS Contract Manager at the end of the twelve month from project commencement and every year thereafter. Three hard copies and an electronic version of the Annual Report shall be submitted. The specific contents of the Annual Report will be decided by the Contractor's Project Manager and EOHHS's Contract Manager. The Contractor shall also conduct a briefing for EOHHS staff on the Annual Report.

It is anticipated at this time that the Annual Report shall: (1) describe accomplishments, (2) contain a statistical profile of work activities (e.g. admission screens, utilization reviews, PASRR evaluations) and Medicaid recipients served, (3) assess the efficiency and effectiveness of contract operations, (4) provide suggestions to improve the delivery and cost-effectiveness of care to Medicaid recipients, and (5) recommendation for future project efforts.

EOHHS RESPONSIBILTIES

EOHHS's responsibilities in this engagement shall be to:

- Designate an individual as the Contract Manager who shall serve as a liaison between the Contractor and EOHHS. This individual shall be responsible for reviewing the Contractor's performance to verify compliance with the terms of the Contract and any applicable regulations, advising the provider community of programmatic changes, processing the Contractor's bills, and meeting with the Contractor when necessary.

- Notify the Contractor of any revisions to applicable regulations and billing procedure.

- Provide information to Contractor on the Medicaid recipient and provider populations.

- Provide the Contractor, when necessary and appropriate, the paid claim data for post-payment reviews.

- Provide the Contractor with a listing of EOHHS rules and regulations to determine if a violation exists.

- Review and approve Contractor recommendation as to diagnoses designated for concurrent review.

CONFIDENTIALITY AND PROTECTION OF PUBLIC HEALTH INFORMATION AND RELATED DATA

The successful bidder shall be required to execute a Business Associate Agreement, Data Use Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business

Associate Agreement, among other requirements, shall require the successful bidder to comply with 45 CFR parts 160, 162, and 164, governing Protected Health Information ("PHI") and Business Associate under the Health Insurance Portability and Accountability Act (HIPPA), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated thereunder, and as amended from time to time, the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations, and regulations promulgated thereunder, and as amended from time to time, the Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26, and the Rhode Island Confidentiality of Health Care Information Act, R.I. General Laws, Section 5-37.3 et.seq.

The successful Bidder shall be required to ensure, in-writing, that any agent including a subcontractor, to whom it provides Protected Health Information received from, or created or received by and/or through this contract, agrees to the same restrictions and conditions that apply through the above described Agreements with respect to such information.

SECTION 4: TECHNICAL PROPOSAL

The following describes the content (i.e. topics to be addressed) and format required for the submission of the Technical Proposal by interested parties:

- **Executive Summary** – The Executive Summary shall highlight the bidder's; (1) understanding of this procurement, (2) capability and capacity to provide admission screening, utilization review, and PASRR, and (3) other factors that contribute to the bidder's ability to provide quality value-based services.

- **Operational/Administrative Requirements Description** – This section shall describe how the Bidder will meet Operational and Administrative requirements as identified in Section 3 of this RFP related to: (1) their experience, (2) approved review agency certified by the State Department of Health, (3) a Federal approved review organization such as a QIO, (4) referral center, (5) staffing related to the Project Management of this procurement, (6) conduct of coordination functions, (7) provider relation efforts, and (8) proposed sub-contracting, if any.

  The bidder shall attach to their proposal the resumes of proposed staff and include a person loading chart indicating the level of effort for each staff person for each scope of work components (e.g. admission screening, utilization review, PASRR evaluation, and project administration).

  The bidder shall include three references that the State of Rhode Island may contact. The references shall include the name of the organization, a contact person, address, telephone number, and e-mail address. The bidder shall describe for each reference the nature and scope of the work, the dates of the work and indicators of the size and magnitude of the engagement.

- **Admissions Screening Requirements** – This section shall describe how the bidder will meet the Admission Screening Requirements as identified in Section 3 of the RFP as related to: (1) scope and affected cases, (2) client populations, (3) clinical protocol, (4) staffing, (5) intake, (6) in-patient admissions, (7) extensions on length of stays, (8) identification of accident case, (9) identification of disease management cases, (10) notifying parties of decisions, (11) the appeals process, and (12) interfacing with provider responsibilities.

- **Utilization Review and Management Program Descriptions** – This section shall describe how the bidder will meet the Utilization Review and Management Program requirements as described in Section 3 of the RFP as related to: (1) concurrent reviews, (2) retrospective reviews, (3) quality of care assurance, and (4) staffing.
- **PASRR Evaluations-** This section shall describe how the bidder will meet the PASRR Evaluation requirements as described in Section 3 of the RFP as related to: (1) Scope of evaluations, (2) screen/evaluation process, (3) shared responsibilities, (4) staffing, and (5) evaluator functions.
- **Implementation Plan-** This section shall include an Implementation Plan that specifies the tasks, activities, and milestones to assure a proper implementation. The State reserves the right to conduct a "readiness review" to assure that the Contractor is able to commence with the scope of work.

  Describe how the bidder will meet the Reporting requirements as described in Section 3 of the RFP as related to: (1) Monthly Report, (2) Scope of Work Specific Reports, and (3) the Annual Report.

SECTION 5: COST PROPOSAL

The cost proposal should identify the proposed cost and budget for each of the projects three base contract years, using Appendix C- Cost Proposal Forms, for each component of the scope of work including:

- **Admission Screening:** The bidder shall indicate the proposed rate that shall be charged per screen for:

  -Inpatient and out-patient admission screen

  -Psychiatric Facility in-patient admission screens

  -NICU Admission Screening

  The proposed charge shall represent an all-inclusive rate that includes fringe benefits, overhead & administrative costs, in direct cost rate, profit and other direct charges that are traditionally associated with conducting admission screenings.

- **Utilization Review and Management:** The bidder shall indicate the proposed rate that shall be charged per utilization review for:

  -Concurrent reviews

  -Psychiatric Facility concurrent/LOS reviews

  -Retrospective & readmission reviews

  -Psychiatric facility retrospective reviews

The proposed charge shall represent an all-inclusive rate that includes fringe benefits, overhead & administrative costs, indirect cost rates, profit and other direct charges that are traditionally associated with conducting admission screenings.

- **PASRR:** The bidder shall indicate the budget for the PASRR evaluations for each of the three base contract years that includes: the hourly rates by staff category, the level of effort, fringe rate, indirect cost rates, overhead/administrative cost rates, other direct charges and profit/savings associated with this function.

- **Project administration and Quality Assurance:** The cost associated with project administrative and quality assurance activities shall be allocated among the other scope of work components.

The cost for Optional Years Four and Five shall be negotiated between the Contractor and the State during the last Quarter of Base Contract Year Three, should the State elect to exercise.

SECTION 6: EVALUATION AND SELECTION

Proposals will be reviewed by a Technical Review Committee comprised of staff from state agencies. To advance to the Cost Evaluation phase, the Technical Proposal must receive a minimum of 60 (85.7%) out of a maximum of 70 technical points. Any technical proposals scoring less than 60 points will not have the cost component opened and evaluated. The proposal will be dropped from further consideration.

Proposals scoring 60 technical points or higher will be evaluated for cost and assigned up to a maximum of 30 points in cost category, bringing the potential maximum score to 100 points.

EOHHS reserves the exclusive right to select the individual(s) or firm (vendor) that it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s).

Proposals will be reviewed and scored based upon the following criteria:

Criteria	Possible Points
Operation/ Administrative	15 Points
Admission Screening	15 Points
Utilization Review and Management	15 Points
PASRR	15 Points
Implementation Plan	10 Points
Total Possible Technical Points	**70 Points**
Cost calculated as lowest responsive cost proposal divided by (this cost proposal) times 30 points *	30 Points
Total Possible Points	**100 Points**

*The Low bidder will receive one hundred percent (100%) of the available points for cost. All other bidders will be awarded cost points based upon the following formula:

(low bid /vendors bid) * available points

For example: If the low bidder (Vendor A) bids $65,000 and Vendor B bids $100,000 for monthly cost and service fee and the total points available are Thirty (30), vendor B's cost points are calculated as follows:

$65,000 / $100,000 x 30= 19.5

Points will be assigned based on the offeror's clear demonstration of his/her abilities to complete the work, apply appropriate methods to complete the work, create innovative solutions and quality of past performance in similar projects.

Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

SECTION 7: PROPOSAL SUBMISSION

Questions concerning this solicitation may be e-mailed to the Division of Purchases at david.francis@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. Please reference **RFP # 7550811** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-8100.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties will be permitted**. Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Responses **(an original plus five (5) copies)** should be mailed or hand-delivered in a sealed envelope marked "**RFP# 7550811 ADMISSION SCREENING AND UTILIZATION REVIEW MANAGEMENT** " to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled

due date and time will be determined to be late and will not be considered. Proposals faxed, or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

RESPONSE CONTENTS
Responses shall include the following:

1. One completed and signed three-page R.I.V.I.P generated bidder certification cover sheet (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.

2. One completed and signed W-9 (included in the original copy only) downloaded from the RI Division of Purchases Internet home page at www.purchasing.ri.gov.

3. **A separate Technical Proposal** describing and substantiating the bidder's; (1) understanding of this procurement, (2) capability and capacity to provide admission screening, utilization review and management, and PASRR evaluations, and (3) other factors that contribute to the bidder's ability to provide quality value-based services related to all information described earlier in this solicitation. The Technical Proposal is limited to 50 single-spaced pages using a font not smaller than 12 points, excluding any attachments the interested party would like to share with EOHHS. As appropriate, resumes of key staff that will provide services covered by this request shall be submitted.

4. **A separate, signed and sealed Cost Proposal** reflecting the proposed cost and budget for each of the projects three base contract years for each component of the scope of work, and demonstrating the bidder's financial capability to conduct this engagement using Appendix C- Cost Proposal Forms.

5. In addition to the multiple hard copies of proposals required, Respondents shall provide their proposal in **electronic format** (**flash, or "thumb" drive**). Microsoft Word / Excel OR PDF format is preferable. Only 1 electronic copy is requested and it should be placed in the proposal marked "original".

CONCLUDING STATEMENTS

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the RFP. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL: https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf .

APPENDIX A

GLOSSARY OF TERMS

Acute Inpatient Hospital: a facility that is licensed as a hospital by the Rhode Island Department of Health (DOH) and that provides diagnosis and treatment for patients who have any of a variety of medical conditions requiring daily physician intervention, as well as full-time availability of physician services. This does not include any facility that is licensed as a chronic disease and rehabilitation hospital, any hospital that is licensed primarily to provide mental health services, or any unit of a facility that is licensed as a skilled nursing facility, an intermediate care facility, a chronic disease unit or a rehabilitation unit. Out of state hospitals must be licensed by their state equivalent of the Rhode Island DOH and be JCAHO approved.

Administrative Necessary Day (AND): a day of inpatient hospitalization on which a lower-than-acute level of care is appropriate, but on which an appropriate placement is unavailable.

Admission: admission or readmission to the same hospital and/or a transfer to another hospital.

Admitting Provider is the provider admitting the recipient to the hospital and assumes primary responsibility for the recipient's care during the hospital stay.

Alternate Care Setting: a health care setting other than an acute inpatient hospital setting.

Ancillary Services: hospital services excluding room and board and office visit charges.

BHDDH: the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

Concurrent Review: a review of the medical necessity and appropriateness of services provided to recipients coinciding with the period of time within which a provider renders the services.

Consultation: a physical examination arranged by EOHHS/designated Contractor and performed by a qualified consultant.

Consultation/Comprehensive: a prolonged visit necessitating history and examination, extensive review of prior medical records as indicated and compilation and assessment of date for the purpose of determining the medical necessity of the proposed surgery.

Consultation/Standard: a visit necessitating history and examination, review of prior medical records as indicated, and compilation and assessment of data for the purpose of determining the medical necessity of the proposed surgery

Contractor: the organization that successfully bids on the RFP and enters into a contract with EOHHS to meet the purposes specified in this RFP.

DCYF: the Rhode Island Department of Children, Youth and Families.

DHS: the Rhode Island Department of Human Services.

Disagreements: a determination that an admission, length of stays, or extended stay is not medically necessary or that the level of care could be safely provided in a less expensive setting.

Discharge Planning: the coordinated effort with the discharge-planning staff of a hospital to locate appropriate placement for recipients who no longer require hospitalization.

DRG: acronym for Diagnostic Related Group

Elective Surgery: a surgery that need not be performed on an emergency basis.

Emergency Surgery: surgery that must be performed without delay because such a delay would unfavorably affect the outcome of surgery.

EOHHS: The Rhode Island Executive Office of Health and Human Services.

Health Care Records: medical records, billing records, or any other relevant documentation indicating services were rendered.

Health Plan: provides or otherwise makes available to enrolled participants health care services including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage.

Medicaid: The Medical Assistance Program administered by EOHHS pursuant to R.I.G.L. 40-8 and Title XIX of the Social Security Act to furnish and pay for medical services to Medical Assistance recipients.

MMIS (Medicaid Management Information System): a system of software, hardware, and manual processes used to process Medicaid claims and to retrieve and produce service utilization and management information, as defined by Part 11 of the State Medicaid Manual and 42 CRF 433.

NICU: A neonatal intensive care (or "special care") nursery in an Acute Inpatient Hospital.

Non-Confirming Opinion: a recommendation by the consultant for further diagnostic evaluation(s) or treatment alternatives.

Non-Elective Admission: admissions that occur on an urgent basis and that the admitting provider determines that the timing of the admission is crucial to a positive clinical outcome.

Peer Review: an evaluation conducted by a qualified professional of the quality, necessity and efficiency of medical services furnished by a provider to determine compliance with statutes, rules and regulations under which the Medical Assistance Program is administered.

Post-Payment Review: a retrospective review that occurs subsequent to reimbursement for said services.

Prepayment Review: a retrospective review that occurs prior to payment of said services.

Provider: a licensed individual, group, facility, agency, institution, organization, or business that has contracted with EOHHS to provide medical services through the Medical Assistance Program.

Pre/Prior authorization: Activity performed by a provider to obtain authorization for a hospital admission, length of stay or procedure.

Psychiatric Facility: a facility licensed as a psychiatric hospital/facility.

Qualified Health Care Organization: is an agency familiar with the health care system either through direct patient care, administration, or as an insurer.

Qualified Medical Consultant: is a physician licensed by the Rhode Island Board of Registration in Medicine who is board-eligible or certified in the specialty of the proposed treatment.

Recipient: a person determined by EOHHS to be eligible for medical assistance under the Medicaid Program.

Rehab Facilities: a facility licensed as a rehab hospital/facility.

Retrospective Review: post-payment or prepayment review of the medical or administrative necessity appropriateness of hospital services provided to a Medicaid recipient subsequent to the period of time within which services are rendered by a provider. Individuals determined eligible after discharge or whose health insurance has expired or does not cover the admission will be reviewed.

APPENDIX B
REPORTING REQUIREMENTS

ADMISSSION SCREENING

Admission Screening Activity Report 1

This report identifies the individuals admitted to each hospital that provide opportunities for case management. Frequency: weekly.

Admission Screening Activity Report 2

This report indicates for each type of admission review request (elective, non-elective, and extended-stay requests) number of new requests, cases processed, approvals, denials and cases referred to a physician advisor. Frequency: monthly, quarterly, yearly

Admission Screening Activity Report 3

This report displays information in Admission Screening Activity Report 1 by ICD9 description and code and major diagnostic category. Additionally, it indicates average number of approved days in length of stay by ICD9 description and code and major diagnostic category and indicates for denied admissions the number of days saved using the 50th percentile of length-of-stay tables for appropriate diagnoses. Frequency: monthly, quarterly, yearly

Readmission Report

This report displays information in Admission Screening Report by client, facility, ICD9 description and code, length of time between admissions (up to 180 days) and whether the current admission diagnoses are related to the prior admission diagnoses. Frequency: monthly, quarterly, yearly

Inpatient Extensions - Activity Report

This report indicates the number of extension requests reviewed, the number of requests approved, the number of requests in disagreement, the number of extended days requested, the number of days approved, the number of days in disagreement, the difference between days requested and days approved - by facility, major diagnostic category and ICD9 description and code. Frequency: monthly, quarterly, yearly

Disagreement Reviews Report

This report indicates length-of-stay disagreements referred for retrospective review. It displays number of cases referred, number of days requested, number of days approved, number of days flagged for retrospective review by facility, ICD9 description and code and major diagnostic category. Frequency: monthly, quarterly, year.

Principal Diagnoses

Top 15 diagnoses approved for inpatient admission with number of cases, ICD- 9 description and code, high, low and average length of stays approved per diagnosis. Frequency: monthly, quarterly, yearly

Hospital ALOS by Diagnoses

This report indicates Average Length of Stay (ALOS) by the Top 15 diagnoses and facility.

Inpatient Denial Report

This report identifies number, percent, and reasons for denial of inappropriate admissions and/or days by facility, ICD9 description, and major diagnostic category. Frequency: Monthly, quarterly, yearly

Cases Resulting from Accidents Report

This report lists and tallies cases which have been identified in the admission screening process as resulting from an accident such as, but not limited to: auto, household, other travel, workplace, commercial properties and crime. The report will include the following:

- recipient name and address,
- recipient's social security number/ identification number,
- admission date,
- primary and secondary diagnoses, and
- date and type of accident.
- Frequency: weekly, monthly
- Internal Quality Monitoring

This report will demonstrate the Contractor's pattern of activity (approvals/denials/avoids) for the previous quarter compared with a DRG environment, by facility. Frequency: quarterly.

UTILIZATION REVIEW AND MANAGEMENT REPORTS

Consolidated Inpatient Utilization Report

This report presents summary information for cases discharged during the specific period. The report displays total Medicaid discharges; total Medicaid inpatient days, average length of stay by facility and ICD9 description. Frequency: quarterly, yearly.

Consolidated Inpatient Review Activity Report

This report presents summary information for cases reviewed and completed during the specified period. The report displays total admissions (requested and approved), number of admissions redirected to an outpatient setting, number of denials, number of days denied, number of extensions (requested and approved), number of extensions disagreed, number of referrals to staff consultant/ physician, inpatient days and average days approved per case. Frequency: monthly, quarterly, year.

Concurrent Review Activity Report

This report conveys level of review activity for concurrent review. Report indicates number of cases reviewed, admission date and expected discharge date, number of cases resulting in savings, number of State days saved by ICD9 description, major diagnostic category, facility, provider and age of recipient. For psychiatric and substance-abuse cases, track those cases with involvement by another state agency such as the Institute of Mental Health or the Department of Children, Youth and Families (DCYF). Report should compare cases reviewed concurrently out of total admissions in relevant diagnoses over time. Frequency: monthly.

Appeals Report

This report indicates the number (and percent) of cases denied, the number (and percent) of days denied, the number (and percent) of denials appealed, the number (and percent) of days appealed, the number (and percent) of appeals upheld and denied by facility, ICD9 description and major diagnostic category. Frequency: quarterly, yearly.

Quality Assurance Report

The Contractor shall submit a proposal for performance of acute patient service reviews and data on quality assurance monitoring on a statewide and, when appropriate hospital-specific basis. Such data shall include a quarterly report, which indicates case-specific instances where there are two, or more disagreements cited for any individual attending physician. The report shall indicate the physician's name or code, the facility in which services were rendered, primary diagnosis and procedure, and reasons for disagreement. The report shall be supplemented with back-up case-specific review information. Frequency: quarterly, yearly.

Quality Assurance Activity Reports

These reports will indicate:

- Cases requiring interventions by on-site Continuing Care Nurse,
- Cases referred to Disease Management / Chronic Care Programs,
- Cases meeting premature discharge criteria and subsequent denials.

Frequency: quarterly, yearly, ad hoc

Retrospective Review Activity Report

This report indicates the number of cases reviewed, number of cases denied, number of days reviewed, number of days denied, and number of denials appealed by facility, ICD9 description and major diagnostic category. Frequency: monthly, quarterly, yearly.

NICU AND SPECIAL REPORTS

NICU Admission Report

This report indicates admissions to NICU by Health Plan, weight, gestational age and primary and secondary diagnoses and discharge status (e.g., normal newborn, home, acute hospital, SNF, other facility.) This report will also include average length of stay (ALOS) by diagnosis and the following weight categories:

Less than 1000 grams,

1000-1500 grams,

1501-2000 grams, AND

Greater than 2000 grams

Frequency: Monthly, quarterly, yearly

Length of Stay – NICU

This report includes the Requested Authorization by the NICU and the approved length of stay by the following categories:

Weight

Gestational Age

Diagnosis (Primary and Secondary)

Procedures (Primary and Secondary)

Health Plan

Frequency: Monthly, quarterly, yearly

Inpatient Extensions - Activity Report

This report indicates the number of extension requests in disagreement, the number of extended days requested, the number of days approved, the number of days in disagreement, the difference between days requested and days approved - by facility, major diagnostic category and ICD9 description and code. Frequency: monthly, quarterly, yearly.

PSYCHIATRIC FACILITY REPORTS

Psychiatric Facility Admission Report

This report indicates admissions to psychiatric facilities by age, primary State Agency, reason for admission and continued stay, discharge plan and primary and secondary diagnoses. This report will also include average length of stay (ALOS). This report will separate out individuals who are under DCYF and create a separate report for this group. Frequency: Monthly, quarterly, yearly.

Psychiatric Facility Length of Stay

This report includes the Requested Authorization by Psychiatric Facilities and the approved length of stay by the following categories:

- Age
- Diagnoses
- Authorizing State Agency
- Discharge Plan

Frequency: Monthly, quarterly, yearly. Readmission Report

Readmission Report

This report displays information in Admission Screening Report by client, facility, ICD9 description and code, length of time between admissions (up to 180 days) and whether the current admission diagnoses are related to the prior admission diagnoses. Frequency: monthly, quarterly, yearly.

Inpatient Extensions - Activity Report

This report indicates the number of extension requests reviewed, the number of requests approved, the number of requests in disagreement, the number of extended days requested, the number of days approved, the number of days in disagreement, the difference between days requested and days approved - by facility, major diagnostic category and ICD9 description and code. Frequency: monthly, quarterly, yearly.

Disagreement Reviews Report

This report indicates length-of-stay disagreements referred for retrospective review. It displays number of cases referred, number of days requested, number of days approved, number of days flagged for retrospective review by facility, ICD9 description and code and major diagnostic category. Frequency: monthly, quarterly, yearly.

Principal Diagnoses

Top 15 diagnoses approved for inpatient admission with number of cases, ICD9 9 description and code, high, low and average length of stays approved per diagnosis. Frequency: monthly, quarterly, yearly.

Hospital ALOS by Diagnoses

This report indicates Average Length of Stay (ALOS) by the Top 15 diagnoses and facility. Frequency: Monthly, quarterly, yearly.

DISEASE MANAGEMNENT REPORTS

Disease Management Diagnoses Admission Report

This report indicates admissions to acute inpatient facilities by primary and secondary diagnoses, co-morbidities, age, physician, and reason for admission and continued stay and discharge plan. This report will also include average length of stay (ALOS). Frequency: Monthly, quarterly, yearly.

Disease Management Diagnoses Length of Stay

This report includes the Requested Authorization by inpatient facilities and the approved length of stay by the following categories:

- Diagnoses
- Age
- Co-morbidities
- Physician
- Discharge Plan

Frequency: Monthly, quarterly, yearly.

Other Disease Management Reports

EOHHS reserves the right to request additional reports

PASRR

The Contractor shall submit reports required by BHDDH.

APPENDIX C

COST PROPOSAL FORMS

ADMISSION SCREENING

Cost Per Screen Rate	Year One	Year Two	Year Three
Inpatient/outpatient admission screens			
Psychiatric facility inpatient admission screens			
NICU Admission Screening			

UTILIZATION REVIEW AND MANAGEMENT

Concurrent and Retrospective Reviews

Cost Per Review Rate	Year One	Year Two	Year Three
Concurrent review			
Psychiatric facility concurrent/LOS review			
Retrospective/Readmission Review			
Psychiatric facility retrospective review			

RATES USED FOR PER SCREEN AND REVIEW COSTS

Rates	Year One	Year Two	Year Three
Fringe Rate			
Indirect Cost Rate			
Overhead/Administrative Cost Rate			
Other Direct Charge Rate			
Profit/Savings Rate			

PASRR EVALUATIONS

Category	HOURS	RATE	Year 1	Year 2	Year 3
Wages by Staff/Category					
Total Wages					
Fringe Benefit Rate (Specify:____)					
Total Wages with Fringe					
Other Direct Costs					
Overhead, Administrative, Indirect Cost Rate (Specify:_____)					
Profit (Specify:_____)					
Total Cost					